STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787 NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0000		3851 N	ADDRESS, CITY, STATE, ZIP CODE RIVER RD LAFAYETTE, IN47906 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X3) DATE SURVEY COMPLETED 09/30/2011 (X5) COMPLETION DATE	
Ti Co vi su Co Si re F2 Co Si Di Vi Co Si Ni To Co M M Or	omplaint Number resulted in a rvey-substand omplaint number lated to the allered	eptember 28 & 29, 2011 r dates: September 30, : 001134 er: 155787 200817200 , RN, TC , RN RN (9/28/11 & 9/29/11) e:	F0000	This Plan of Correction is a center's credit allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider truth of the facts alleged or conclusions set forth in the statement of deficiencies. plan of correction is prepara and/or executed solely because is required by the provision federal and state law.	ble on of not of the The ed ause it

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 92XM11

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET COMPLET				
155787			A. BUILDING	G		09/30/2	
		100707	B. WING	DEET AF	DDRESS, CITY, STATE, ZIP CODE	03/00/2	J 1 1
NAME OF P	ROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME				AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
mo	Total: 206	ESC ISENTIL TING IN ORMATION)	171				DATE
	200						
	Sample: 8						
	NCC Sample: 4						
	Supplemental Sa	mple: 7					
	• •	•					
	These deficiencie	es also reflect state					
	findings cited in	accordance with 410 IAC					
	16.2.						
	Quality review completed on October 3,						
	2011 by Bev Fau	lkner, RN					
F0223		he right to be free from					
SS=D		/sical, and mental abuse,					
	corporal punishme seclusion.	ent, and involuntary					
	•	ot use verbal, mental,					
	sexual, or physical	oluntary seclusion.					
		review and interview, the	F0223		1. What action was taken to		10/31/2011
		ensure residents were not	- 0220		correct the deficient practice		
	•	elated to verbal abuse for			affected residents? Families		
	•	with incidents of alleged			doctors were notified immedi- for residents involved in repo	,	
		e of 15. (Residents #E,			incidences 2. How are other		
	#H, #I).				identified and what corrective		
					action will be taken to preven from occurring to others? a)		
	Findings include				alert and oriented residents		
					hillwide were interviewed to		
	1. Resident #E's	clinical record was			determine if there were any s concerns, any safety concern		
	reviewed on 9/29	7/11 at 10:05 A.M. The			and to alert them on how to r		
	record indicated	the resident was admitted			any concerns b) All staff wer		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 92XM11 Facility ID:

001134

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155787		LDING	00	09/30/2	
		100101	B. WIN		DDDECC CITY OF TE CORE	03/30/2	V 1 1
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE RIVER RD		
INDIANA	VETERANS HOME	Ξ			_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	inserviced on abuse policies	and	DATE
	1	which included, but were			abuse reporting procedures		
	not limited to, di	·			alert and oriented residents v		
	hypertension, an	d depression.			educated on the different typ		
	1.16 ·	C + A FDC) O - + 1			abuse 3. What measures or		
		a Set (MDS) Quarterly			systemic changes were put in place to be sure this does no		
		ed 9/8/11, indicated the			re-occur? a. We are extend		
	resident had severe cognitive impairment, had no behaviors, did not transfer or				our investigative procedures	to	
					include more in-depth staff interviews and resident interv	,iowe	
	, ,	ed extensive one-person			on all alleged incidences. b.		
		ce for bed mobility, and			have changed our investigati		
	was totally dependent on two-person physical assistance for toilet use.				form to assist in the above (a	•	
	pnysical assistan	ce for toffet use.			How will corrective actions be		
	A	-4-1 <i>E</i> /1 <i>E</i> /11 -4 10:00			monitored? Investigations are being audited through our Q/		
	•	ated 5/15/11 at 10:20			process daily x60 days, weel		
		Spoke c (with) brother.			x90 days, then monthly		
	_	llegedly an employee may			thereafter by the DON. 5. When will all changes be complete? October 31 st , 2011		
	_	uptly to resident and that					
		nd voices 0 (no) concerns			0000001 01 30 , 2011		
		lent is being investigated					
		volved will not be					
		(Indiana Veteran's Home)					
	until investigated	1."					
	A social service	progress note, dated					
		ed "Met with res (resident)					
	· ·	poke with her regarding					
		e may have. Res states she					
	1	and is doing well. No					
		ns of emotional distress					
	present."	no or emotional distress					
	present.						
	A "Facility Incid	lent Reporting Form,"					
	1	2:00 P.M., indicated					
		on of Incident:(Resident					

NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME WEST LAFAYETTE, INAT906 (X5) COMPLETED 3851 N RIVER RD WEST LAFAYETTE, INAT906 INDIANA VETERANS HOME WEST LAFAYETTE, INAT906 INDIANA VETERANS HOME WEST LAFAYETTE, INAT906 INDIANA VETERANS HOME INDIANA VETERANS HOME INDIANA VETERANS HOME WEST LAFAYETTE, INAT906 INDIANA VETERANS HOME INDIANA VETERANS		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	
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the Director of Nursing indicated the		the investigation	was completed.					
the Director of Nursing indicated the		Interview on 9/2	9/11 at 8:50 Δ M with					
			•					
LOOCHHEMAHOLOLALVIMEIVIEWS I I I			_					
conducted related to the investigation of								
the above incident couldn't be found. She			· ·					
indicated "they took statements but								
(ADON #1) can't find them."								
		(== 0=\ 1) 341 1						
An e-mail from RN #1 to the DON,		An e-mail from	RN #1 to the DON,					
ADON #1, ADON #2, and Unit Manager			· · · · · · · · · · · · · · · · · · ·					
#2, dated 5/16/11 at 4:51 A.M., provided		•	•					
by the Director of Nursing indicated "			_					
(CNA #7) and (CNA #6) witnessed		•	•					
(Resident #E) asking to go to bed								
numerous times in the dining room and								
when going by the nurses station (CNA								
#5) came around in front of her, with her								

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE COMPL	
		155787	A. BUII B. WIN			09/30/2	011
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER	•			RIVER RD		
INDIANA	VETERANS HOME			WESTL	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		s of the w/c (wheelchair) 's words was loud and					
	` ′	ldn't lay down she had to					
		en (Resident #E) loudly					
		A #5) said 'You don't					
	• `	me, just ask nicely'.					
		er voice was 'mimicky'					
	` ′	. #6) said (CNA #5) said					
	`	rait her turn(CNA #7)					
		VA #5) not to talk that					
	· ·	tate came up it could be					
	seen as abuse'. (C	CNA #5) said she just					
	wanted (Residen	t #E) to hear her and					
	(CNA #7) said sl	ne told her that she was					
	close enough to l	be heard. (CNA #6) said					
	she asked (Resid	ent #E) if she was ok and					
	(Resident #E) sai	id 'Yes' and she then had					
	someone else put	t (Resident #E) to bedI					
	· · · · · · · · · · · · · · · · · · ·	nd (CNA #6) that this					
		reported immediately to					
	the supervisor on	ı duty"					
		he DON to the ADON,					
		6:38 P.M., indicated "I					
		on this this (sic) am but					
		said all this. (CNA #7)					
		seled on appropriate					
	-	cumentation was lacking					
		45's behavior. A reply					
		ADON #1 to the DON,					
		11:30 A.M., indicated ve the written statements					
		ve me written statements					
	yet"						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

92XM11 Facility ID:

001134

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		LDING	NSTRUCTION 00	(X3) DATE COMPL 09/30/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	1		DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOMI	≣		RIVER RD .AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated "We do because there was decided to use ed	ed 5/23/11 at 8:34 A.M., on't feel it was abuse as no willful intent we ducation."				
	ADON #1, dated	Social Services #1 to 15/23/11 at 4:22 P.M., d not interview any other				
	The CNA was inserviced on abuse on 5/21/11.					
	A "Permanent Record of Assignment," dated 9/23/11, indicated CNA #5 had been scheduled to care for Resident #E. Documentation was lacking in CNA #5's employee file to indicate there had been any disciplinary action taken related to the above incident.					
	Unit Manager #2 "was upset with "if you just touclindicated CNA #	9/11 at 10:07 A.M. with 2 indicated the resident CNA #5." She indicated he her she gets upset." She #5 had been assigned to incident but "she's not				
	reviewed on 9/30	clinical record was 0/11 at 12:35 P.M. The the resident was admitted				

NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) with diagnoses which included, but were not limited to, chronic obstructive lung disease and myocardial infarction. A Minimum Data Set (MDS) annual assessment, dated 7/5/11, indicated the resident was cognitively intact. A nurses' note, dated 5/5/11 at 5:45 P.M., indicated "Res came to Nursing Station & reported that 'a girl in a blue outfit & she was just in there cussing me & (roommate name) out.' Res' I told her I didn't know her & never seen her before & she was	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
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INDIANA VETERANS HOME (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) with diagnoses which included, but were not limited to, chronic obstructive lung disease and myocardial infarction. A Minimum Data Set (MDS) annual assessment, dated 7/5/11, indicated the resident was cognitively intact. A nurses' note, dated 5/5/11 at 5:45 P.M., indicated "Res came to Nursing Station & reported that 'a girl in a blue outfit & she was just in there cussing me & (roommate name) out.' Res 'I told her I didn't know her & never seen her before & she was	NAME OF P	ROVIDER OR SUPPLIER	₹					
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (ACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE With diagnoses which included, but were not limited to, chronic obstructive lung disease and myocardial infarction. A Minimum Data Set (MDS) annual assessment, dated 7/5/11, indicated the resident was cognitively intact. A nurses' note, dated 5/5/11 at 5:45 P.M., indicated "Res came to Nursing Station & reported that 'a girl in a blue outfit & she was just in there cussing me & (roommate name) out.' Res 'I told her I didn't know her & never seen her before & she was								
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indicated "Res came to Nursing Station & reported that 'a girl in a blue outfit & she was just in there cussing me & (roommate name) out.' Res 'I told her I didn't know her & never seen her before & she was		A nurses' note d	lated 5/5/11 at 5:45 P M					
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was just in there cussing me & (roommate name) out.' Res 'I told her I didn't know her & never seen her before & she was			C					
name) out.' Res 'I told her I didn't know her & never seen her before & she was								
her & never seen her before & she was		"	· ·					
		· · · · · · · · · · · · · · · · · · ·						
i irving to sav sometning about old beoble."			nething about old people.'					
Res reported he had his light on prior to								
this to get assistance"		_						
		8						
A "Facility Incident Reporting Form,"		A "Facility Incid	lent Reporting Form,"					
dated 5/5/11 at 6:30 P.M., indicated "								
(Resident #H) stated that (CNA #10)								
came to his room and stated she was tired		` '						
of old people trying to run things. She		of old people try	ring to run things. She					
also the (sic) resident that she didn't need		1 1 2	· ·					
this job(Resident #H) also stated that he								
felt that (CNA #10) didn't need to speak		` `	<i>'</i>					
to them in the manner she had"			· -					
A handwritten statement, dated 5/5/11 (no		A handwritten st	tatement, dated 5/5/11 (no					
time) and signed by CNA #10, indicated		time) and signed	by CNA #10, indicated					
"I tried (sic) to talk to him till he tried		"I tried (sic) to	talk to him till he tried					
(sic) to pull some racial crap. I told him I		(sic) to pull som	e racial crap. I told him I					
ain't racial but I am done w (with) that			_					
room & their attitudes. Socks changed &			* *					

001134

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
		155787	B. WIN			09/30/2	011
	PROVIDER OR SUPPLIER			3851 N	.DDRESS, CITY, STATE, ZIP CODE RIVER RD .AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	everything picke I've explained it.	d up. I did my job. Now Goodnite"					
	6:30 P.M., indicatincident/allegation abuse Yes (circulation for the asked not to return the desired procumentation of the staff being above incident of the asked not to return the desired procumentation of the staff being above incident of the ago. I was sominding my own in. I didn't know what she wanted hell up, you old procumentation of the staff being above incident #H indicated hell up, you old procumentation what she wanted hell up, you old procumentation in the staff being above.	on meet the definition of led)Unsubstantiated sckmark)Agency CNA rn to IVH" was lacking related to any interviewed related to the f alleged abuse. 0/11 at 12:45 P.M., with cated "That was a long itting in my room business and a girl came who she was. I asked and she told me 'Shut the people don't know what t and turned her in. I led to like that." He I not been back to his					
	reviewed on 9/30 record indicated with diagnoses w not limited to, br	elinical record was 0/11 at 10:00 A.M. The the resident was admitted which included, but were onchospastic lung and history of congestive					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155787	B. WIN	G		09/30/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
INIDIANIA	VETERANG HOM	_			RIVER RD		
	VETERANS HOM			WEST	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAU		ta Set (MDS) quarterly		TAG			DATE
		d 3/29/11, indicated the					
	-	nitively intact and was					
		ransfer, ambulation, and					
	toilet use.	ransier, amouration, and					
	tonet use.						
	A nurses' note d	lated 5/5/11 at 6:30 P.M.,					
		r spoke c (with) Res &					
		taff) was in her taking					
	`	te name) then she popped					
	`	turned my scooter and					
		y closet door. He then said					
		ver to the other side & I					
		my scooter on & she					
		off & she said I could					
		f.'She also told us 'Well					
	_	can't sit around & sleep					
		guys doI was going to					
		mmate name) beat me to					
	it."	minate name) beat me to					
	16.						
	A "Facility Incid	lent Reporting Form,"					
	1	licated "She had moved					
		lectric scooter and didn't					
	` '	(Resident #I) asked					
	· · · · · · · · · · · · · · · · · · ·	rn the scooter off she					
	stated 'turn it off						
		yoursen.					
	An "Investigation	n" form, dated 5/5/11,					
	_	the incident/allegation					
		on of abuseYes					
		ostantiated (indicated by					
	` ′	gency CNA asked not to					
	return to IVH"						
	1214111 10 1 1 11						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155787	1	LDING	00	09/30/2	
		100707	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	011
NAME OF P	PROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCT)		DATE
	Do aumontation v	was lacking related to					
		pers being interviewed					
		ove incident of alleged					
	abuse.	ove incident of aneged					
	abuse.						
	Interview on 9/30	0/11 at 10:10 A.M., with					
	Resident #I indic	cated "We have some					
	problems with so	ome of them (staff) but I					
	don't know what	you're talking about."					
	Review on 9/28/	11 at 11:30 A.M., of a					
	facility policy an	d procedure dated					
	10/20/06, provid	ed by the Assistant					
	Administrator, id	lentified as current, and					
	titled "Abuse Ide	entification, Prevention					
	and Reporting" in	ndicated "This facility					
	operates under a	zero tolerance of abuse					
	policyIt is the i	ntent of the Indiana					
	Veterans' Home	to assure that all					
	Residents of this	facility are free from					
	physical, sexual,	verbal and/or mental					
	(known and/or al	lleged) abuse, corporal					
	punishment, and	involuntary seclusion.					
		relates to Complaint					
	Number IN0009'	7132.					
	3.1-27(b)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/30/20	ETED
	PROVIDER OR SUPPLIER			3851 N I	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0225 SS=E	have been found or mistreating residuate had a finding nurse aide registry mistreatment of residual from their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the investigation is the representative and accordance with State survey and oworking days of the side of the	nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					
	facility failed to allegations of about investigated relations	ew and record review, the ensure all alleged use were thoroughly ted to verbal abuse by residents with allegations	F0	225	 What action was taken to correct the deficient practice affected residents? Families doctors were notified immedi for residents involved in repo incidences 2. How are other 	for and ately rted	10/31/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155787	B. WIN			09/30/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			RIVER RD		
INDIANA	VETERANS HOMI				LAFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	_	DATE
		nple of 15. (Residents #E,			identified and what correctiv action will be taken to preve		
	#F, #G, #J, and #	‡K).			from occurring to others? a)		
					alert and oriented residents		
	Findings include	y:			hillwide were interviewed to		
					determine if there were any		
	1. Resident #E's	clinical record was			concerns, any safety concer and to alert them on how to		
	reviewed on 9/29	9/11 at 10:05 A.M. The			any concerns b) All staff we		
	record indicated	the resident was admitted			inserviced on abuse policies		
	with diagnoses v	which included, but were			abuse reporting procedures		
	not limited to, di	abetes mellitus,			alert and oriented residents		
	hypertension, and depression.				educated on the different type abuse 3. What measures o		
					systemic changes were put		
	A Minimum Dat	a Set (MDS) Quarterly			place to be sure this does no		
		ed 9/8/11, indicated the			re-occur? a. We are extend	ling	
	· ·	ere cognitive impairment,			our investigative procedures	to	
		s, did not transfer or			include more in-depth staff interviews and resident inter	viowe	
		ed extensive one-person			on all alleged incidences. b.		
	_	ice for bed mobility, and			have changed our investigat		
		ndent on two-person			form to assist in the above (a		
		-			How will corrective actions l		
	physical assistan	ice for toffet use.			monitored? Investigations at		
	A				being audited through our Q process daily x60 days, wee		
		ated 6/13/11 at 11:45			x90 days, then monthly there		
		Resident told SW (social			by the DON. 5. When will a	ıII	
	· ·	was upset c (with) CNA			changes be complete? Octo	ber	
	` ′	(with) her earlier during			31 st , 2011		
	care (see SW no	te 6/13)"					
		es Notes," dated 6/13/11,					
		r went to meet res					
	` ′	room to conduct					
		ognitive tests). Res					
	immediately tell	s writer she is upset. Res					
	explains that she	was treated roughly by					
	an aide when she	e was turning her. Nurse					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			LDING	nstruction 00	(X3) DATE (COMPL 09/30/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	came into the room and listened to resident's concern. Re-assured res that aide will no longer be providing her care"							
	12:00 P.M., and a CNA in the alleg	ote, dated 6/13/11 at signed by CNA #8 (the ation) indicated no dling the resident had						
	11:30 A.M., and indicated "Writer complete tx. Res negative deamen (without) difficult complete ADLs (living)." Docum related to the alle	ote, dated 6/13/11 at signed by RN #2 r was in res room to was in bed c (with) er (sic). Tx completed s lty. CNA into res room to (activities of daily entation was lacking egation of roughness of re were no other staff ble for review.						
	indicated "Did meet the definition (circled)CNA	could return after policyUnsubstantiated						
	6/13/11, indicate	SS #1 to ADON #2, dated d "She was upset today told the aide would not or her"						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155787	B. WIN	G		09/30/20	011
NAME OF PE	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					RIVER RD		
INDIANA '	VETERANS HOME			WEST L	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A	A DON #2 45 Classic #1					
		ADON #2 to Clerk #1,					
	*	, and SS #1, dated ed "(CNA #8 may come					
	•	e the agency go over					
		th her and send doc					
		of such. Also SS rec					
	,	nat maybe she not work					
	on (unit name) for						
	on (unit name) it	JI J-4 WCCKS					
	Interview on 9/2	9/11 at 10:00 A.M., with					
		aired Resident #E, when					
		ated her well, first					
		then indicated yes.					
	marcated no and	then indicated yes.					
	Interview on 9/2	9/11 at 1:00 P.M., with					
	ADON #1 indica	ated if staff didn't witness					
	the alleged incide	ent of abuse, no staff					
	were interviewed						
	2. Resident #K's	clinical record was					
	reviewed on 9/30	0/11 at 10:15 A.M. The					
	record indicated	the resident was admitted					
	with diagnoses w	which included, but were					
	not limited to sev	vere degeneration of left					
	shoulder, and sch	nizophrenia.					
		a Set (MDS) 5-Day					
		d 8/26/11, indicated the					
		derately impaired in					
	•	on-making skills, was					
		and required extensive					
	two-person phys	ical assistance for toilet					
	use.						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/30/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		 STREET A	DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME			RIVER RD .AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	dated 5/15/11 at (Resident #K) was the hallway yellicoverheard to say quiet or he would BINGOThe number of the stream of the second of the resident and asked to care for the resident and a	ent Reporting Form," 2:00 P.M., indicated " as sitting in his recliner in ng out and (CNA #5) was to (Resident #K) to be d go to bed and not go to rse removed the C.N.A. n and counseled her on oppropriately to the ed another staff member sidents" A follow-up "the C.N.A. will have returning to work on her RN #1 to the DON, Manager #2, and ADON I at 4:51 A.M., indicated orted to me that he #5) tell (Resident #K) in n he was yelling to be ld put him to bed and he o to Bingo(Resident ing about his mommy ADON #1 to corporation, 7:12 A.M., indicated was abuse because there tent we decided to use				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUII	LDING	nstruction 00	(X3) DATE (COMPL 09/30/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	3851 N	DDRESS, CITY, STATE, ZIP CODE RIVER RD .AFAYETTE, IN47906		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	9/23/11, indicated "I did not interview any other residents"						
	Documentation was lacking to indicate any other residents or staff had been interviewed related to the above incident of abuse.						
	Interview on 9/29/11 at 8:50 A.M., with the DON indicated statements had been taken from staff and residents but "(ADON #1) can't find them."						
	the Administrato been employed o previously and ha there. He indicate the state hospital	9/11 at 1:00 P.M., with r indicated the CNA had on a psychiatric unit ad cared for Resident #K ed "it's a mindset from ." He indicated CNA #5 ced on the abuse policy ts previously.					
	Resident #K on 9	made to interview 0/30/11 at 10:30 A.M. not respond to questions					
	reviewed on 9/29 record indicated with diagnoses w not limited to, co cerebrovascular a	clinical record was 0/11 at 9:30 A.M. The the resident was admitted which included, but were ronary artery disease, accident (stroke), renal d gastrointestinal bleed.					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155787	B. WIN	G		09/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KO VIDER OR SUITEIEI				RIVER RD		
INDIANA	VETERANS HOMI	E		WEST	_AFAYETTE, IN47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A Minimum Dat	a Set (MDS) cignificant					
	A Minimum Data Set (MDS) significant change assessment, dated 8/9/11,						
	indicated the resident was cognitively intact.						
	A "Facility Incid	lent Reporting Form,"					
		ndicated "The resident					
	-	ted today 9/23/11, that					
		ned her dinner tray down					
	on the table and walked away and didn't						
		sident reported that she					
		e employee" The QMA					
		pending completion of an					
	investigation.	,					
	An e-mail from	RN #3 to ADON #1,					
		ndicated "Resident					
	-	oyee does not like her and					
	•	he resident is afraid of					
		Resident denies that this					
		rmed the resident. The					
		fied by the resident is					
		lent also stated she thinks					
	` ′	oyee is waiting for the					
	opportunity to ir	-					
	An "Investigatio	n" form, dated 9/23/11,					
	_	ident stated that employee					
	slammed a tray down on the over bed						
	1	raid of employeeDid the					
	incident/allegation meet the definition of						
	_	eled)Resident felt it was					
	,	ts were interviewed. No					

155787 D. WING	09/30/2011				
NAME OF PROVIDER OR SUPPLIER 3851 N RIVER RD	STREET ADDRESS, CITY, STATE, ZIP CODE				
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRI	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) CX5) COMPLETION DATE				
other staff presentResident states she has not been harmed but continues to be afraid. She has been using a pocket talker rests on her abd (abdomen) which could have intensified noiseUnsubstantiated (indicated by X)(CNA #9) returned to work & has been re-educated on the policyContinues to be afraid of employee but can't state why" Documentation was lacking related to any other staff being interviewed related to the above incident of alleged abuse. An e-mail from the Psychiatric Services Specialist to ADON #1, dated 9/26/11, indicated "Did you talk to the alert and oriented residents on (unit name) on Friday? If so can you tell me who they were and what they said. I need to get the employee back to work." Interview on 9/29/11 at 1:00 P.M., with ADON #1 indicated no other staff members had been interviewed. She indicated the resident continues to state she's afraid of the employee. ADON #1 indicated "She probably passes meds to her." Interview on 9/29/11 at 1:00 P.M. with the Administrator, indicated "I am not going to hire new staff every time someone says they're afraid of staff. We					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155787		A. BUI	LDING	NSTRUCTION 00	l í	E SURVEY PLETED //2011		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN47906					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	don't have the fur move people aro happen." On 9/29/11 at 9:2 made to interview	nds to do that. I won't und. That's not going to 20 A.M., an attempt was w Resident #F. The entrance to her room and						
	4. Resident #J's or reviewed on 9/30 record indicated with diagnoses w	elinical record was 0/11 at 10:40 A.M. The the resident was admitted which included, but were somnia, depression,						
	assessment, dated resident was seve cognitive decision non-ambulatory,	n-making skills, was and required extensive ical assistance for bed						
	P.M., indicated " a written note, re	ated 6/17/11 at 3:30 Informed by night aide in sident indicated improper by the CNAs from day						
	signed by LPN # #J) told me in a r	ote, dated 6/17/11 and 2, indicated "(Resident not so polite way that 2 got him up or put him to						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155.79.7		(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE S	ETED		
		155787	B. WING	·		09/30/20	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	bed was (sic) ver they bumped his or the hoyer. He I couldn't make of (name)" A "Facility Incid dated 6/16/11, in alert and oriented forgetfulnessHe got him up or pur with him, that the is a hoyer liftPoit was noted that of bed at all that inserviced on the Documentation videntifying who to worked the day of An "Investigation indicated"Did meet the definition (circled)After in	y rough with him that head either on the chair was so worked up over it but which. I reported it to ent Reporting Form," dicated "Resident is with some ereports that 2 aides that thim to bed was 'rough' ey bumped his head. He er investigation with staff resident did not get out dayCNA's will be hoyer lift" was lacking related to the staff was who had of the alleged incident. "" form, dated 6/17/11, the incident/allegation on of abuseYes nvestigation - it was at did not get OOB (out			CROSS-REFERENCED TO THE APPROPRIAT	TE .		
	checkmark)" D lacking related to involved in incid any other staff in	bstantiated (indicated by ocumentation was identification of staff ent or documentation of terviews related to the						
	incident of allege 5. Resident #G's	ed abuse.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155787	B. WIN			09/30/2	011
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULLEIE				RIVER RD		
INDIANA	VETERANS HOMI	E		WESTL	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		CLSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	reviewed on 9/29/11 at 11:00 A.M. The record indicated the resident was admitted						
	_	which included, but were					
	not limited to, po	- 1					
		seizures, difficulty					
		and severe chronic					
	obstructive pulm	ionary disease.					
	A Minimum Dat	ta Set (MDS) quarterly					
		ed 6/16/11, indicated the					
	resident was cognitively intact and was						
	independent in transfers, ambulation, and						
	toilet use.						
	Nurses' notes, da	ated 9/10/11 at 10:30					
	•	"Resident reported to					
	· ·	ave her a shower today,					
	_	a male aide showered her					
	_	with her cross necklace					
	she had on - ano	ther nurse aide stated that					
		old her the same thing but					
	_	ior to that - states					
	-	ing - was possible that					
		shirt off, necklace got					
		e offwhile security was					
	-	sident changed her story					
	to male aide can	ne up behind her while					
		nd choked her with the					
	necklace and the	en took it. Supervisor					
	notified."	-					
	Documentation	was lacking related to an					
	investigation bei	ng conducted the week					
	prior to 9/10/11,	when the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/30/2	ETED	
		155767	B. WIN			09/30/20	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID		FATEMENT OF DEFICIENCIES		ID		1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	reported it to a C	NA.					
	indicated "Met up regarding alle although resident complaint is about allegations, although appear to be evide allegations" A "Facility Incided dated 9/10/11, in but has periods of to a staff member (approximately) was in the shower	ent Reporting Form," dicated "Resident is alert, f confusion. She reported					
	grabbed her cross pull it off. She sa	s necklace and tried to iid it was choking her e does not remember					
	who it was poss ((possibly) a male CNA					
	` ′	he later reports it was male CNA named (name)					
	on schedule to w						
	A handwritten no signed by (CNA also informed mo	ote, dated 9/10/11 and #11), indicated "She that she reported him. w his name, just that he					
	A handwritten no signed by (CNA	ote, dated 9/10/11 and #12), indicated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

92XM11 Facility ID:

001134

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155787			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/30/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	agency '(name)' g shower in late af not heard any iss complaints. About #G) mentioned the behind her & sto a shower from a Mentioned it to (said she had hear already. It happed pulled off her new A handwritten not signed by ADON (with) (LPN #2) c (with) (Resider does not recall be incidents. Inform (policy and proce- returning to IVH & understands the management of a abuse to be invest An "Investigation indicated "Did meet the definition (circled)(CNA policy(LPN #2) policyRes has a statements - (CN	LPN #2) agency nurse - rd something about it ened when her sweater cklace." the, dated 9/12/11 and N #2, indicated "Spoke c per phone about incident int #G). She states she eing informed of any ned her to review P&P edure) on abuse before The She states she is aware ne importance of notifying any c/o (complaints of) stigated!" n" form, dated 9/10/11, the incident/allegation on of abuse Yes #13) reviewed abuse a history of making false TA #13) states he does not g any jewelry & she did						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

92XM11 Facility ID:

001134

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUIL	DING	NSTRUCTION 00	(X3) DATE : COMPL 09/30/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	herselfUnsubstantiated (indicated by checkmark)"						
	the DON, the DO	9/11 at 1:00 P.M. with ON indicated the incident orted or investigated					
	ADON #2 to RN #1, RN #7, the B DON, and ADO! couple of months increase of theft name) which hav The issue is that reportables on or show that we are put something in	aware and that we have placeI will just need to of proof if state would					
	the Administrato says they don't w won't hire addition the staff. It's not can't tell everyon room. I don't care what you (ISDH) Administrator induscuss issues wi	9/11 at 1:15 P.M., with r indicated "If somebody rant staff in the room, I onal staff. I won't replace going to happen. You ee not to come in the ee what CMS says. You do) want." The dicated staff were not to th ISDH unless he was ted staff to leave the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			(X2) MU: A. BUILI		NSTRUCTION 00	(X3) DATE : COMPL	
		155787	B. WING			09/30/2	011
	PROVIDER OR SUPPLIER			3851 N F	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	This federal tag r Number IN00097 3.1-28(d) 3.1-28(e)	relates to Complaint 7132.					
F0226 SS=E	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure facility policies and procedures were implemented related to verbal abuse by staff for 5 of 13 residents with allegations of abuse in a sample of 15. (Residents #E, #F, #G, #J, and #K). Findings include: 1. Resident #E's clinical record was reviewed on 9/29/11 at 10:05 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus,		F02	226	1. What action was taken to correct the deficient practice affected residents? Families doctors were notified immediator residents involved in repoincidences 2. How are other identified and what corrective action will be taken to preven from occurring to others? a) alert and oriented residents hillwide were interviewed to determine if there were any sconcerns, any safety concernand to alert them on how to rany concerns b) All staff were inserviced on abuse policies abuse reporting procedures calert and oriented residents we educated on the different type	for and ately rted rs tit tit All staff ns eport re and c) All vere	10/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155787	B. WIN	G		09/30/20	011
	PROVIDER OR SUPPLIER			3851 N I	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	Assessment, date resident had seve had no behaviors ambulate, require physical assistant was totally deper physical assistant. A nurse's note, da A.M., indicated worker) that she tx (treatment) c (care (see SW not "Social Services indicated "Writer (resident) in her BIMS/PHQ-9 (commediately tells explains that she an aide when she came into the roor resident's concernaide will no long care" A handwritten not 12:00 P.M. and s CNA in the allegent in the service of	a Set (MDS) Quarterly ed 9/8/11, indicated the ere cognitive impairment, did not transfer or ed extensive one-person ce for bed mobility, and endent on two-person ce for toilet use. ated 6/13/11 at 11:45 "Resident told SW (social was upset c (with) CNA with) her earlier during the 6/13)" Notes," dated 6/13/11, to went to meet res			abuse 3. What measures or systemic changes were put in place to be sure this does no re-occur? a. We are extend our investigative procedures include more in-depth staff interviews and resident intervon all alleged incidences. b. have changed our investigatiform to assist in the above (a How will corrective actions be monitored? Investigations are being audited through our QA process daily x60 days, week x90 days, then monthly there by the DON. 5. When will all changes be complete? October 31 st , 2011	nto t ting to riews We on) 4. e e c A kly after	

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	
		155787	B. WIN			09/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME				RIVER RD .AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710				mo			DATE
	A handwritten note, dated 6/13/11 at						
	11:30 A.M. and signed by RN #2, indicated "Writer was in res room to						
	_	was in bed c (with)					
	_	er (sic). Tx completed s					
	` ′	lty. CNA into res room to					
	•	(activities of daily					
	· · · · · · · · · · · · · · · · · · ·	nentation was lacking					
		egation of roughness of					
		re were no other staff					
	interviews availa	ible for review.					
	An "Investigation	n" form, dated 6/13/11,					
	_	the incident/allegation					
		on of abuseYes					
	(circled)CNA	could return after					
	reviewing abuse	policyUnsubstantiated					
	(indicated by che	eckmark)"					
	An e-mail from S	SS #1 to ADON #2, dated					
		ed "She was upset today					
	but calmed when	told the aide would not					
	be back to care f	or her"					
	An e-mail from	ADON #2 to Clerk #1,					
		, and SS #1, dated					
	· ·	ed "(CNA #8 may come					
	· ·	e the agency go over					
		th her and send doc					
		of such. Also SS rec					
	(recommends) th	nat maybe she not work					
	on (unit name) for 3-4 weeks"						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			LDING	00	COMPL	
		155787	B. WIN	G		09/30/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					RIVER RD		
INDIANA	VETERANS HOMI	E		WESTL	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		CLSC IDENTIFYING INFORMATION)		TAG	DIA TELENCT)		DATE
	Interview on 9/29/11 at 10:00 A.M. with cognitively impaired Resident #E, when asked if staff treated her well, first indicated no and then indicated was						
	indicated no and	ndicated no and then indicated yes.					
	Interview on 0/2	9/11 at 1:00 P.M., with					
		ated if staff didn't witness					
		lent of abuse, no staff					
	were interviewed						
	were interviewed	u.					
	2 Resident #K's	s clinical record was					
		0/11 at 10:15 A.M. The					
		the resident was admitted					
		which included, but were					
	1	vere degeneration of left					
	shoulder, and sci	•					
	shoulder, and sc	mzopinema.					
	A Minimum Dat	ta Set (MDS) 5-Day					
		ed 8/26/11, indicated the					
	· ·	derately impaired in					
		on-making skills, was					
	_	and required extensive					
	1	sical assistance for toilet					
	use.	nous assistance for tollet					
	450.						
	A "Facility Incid	lent Reporting Form,"					
	1	2:00 P.M., indicated "					
		as sitting in his recliner in					
		ing out and (CNA #5) was					
		to (Resident #K) to be					
		d go to bed and not go to					
	_	irse removed the C.N.A.					
		on and counseled her on					
		ppropriately to the					
	1 speaking ina	PPTOPTIMETY TO THE					

001134

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUILDING	E CONSTRUCTION 00	COM	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		385	EET ADDRESS, CITY, STATE, ZIP O 1 N RIVER RD ST LAFAYETTE, IN47906	CODE	
(X4) ID PREFIX	SUMMARY ST	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE.	HOULD BE	(X5) COMPLETION
TAG	resident and asket to care for the resident to care for the resident indicated deducation before floor" An e-mail from Fadon Hadon #1, Unit #2, dated 5/16/11 "(CNA #6) reproverheard (CNA the hallway when quiet or she would wouldn't get to go #K) was just cryidying" An e-mail from Adated 9/23/11 at "We don't feel it was no willful in education" An e-mail from So 9/23/11, indicate any other resident interviewed relation fabuse. Interview on 9/29	d another staff member sidents" A follow-up 'the C.N.A. will have returning to work on her RN #1 to the DON, Manager #2, and ADON at 4:51 A.M., indicated orted to me that he #5) tell (Resident #K) in he was yelling to be ld put him to bed and he to to Bingo(Resident ang about his mommy ADON #1 to corporation, 7:12 A.M., indicated was abuse because there tent we decided to use staff had been ed to the above incident with the desident and the above incident staff had been ed to the above incident staff had been ed statements had been ed statements had been	TAG	DEFICIENCY)		DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
		155787	B. WIN	G		09/30/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOMI	E			RIVER RD AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		and residents but		_			
	"(ADON #1) can't find them."						
	Interview on 9/29/11 at 1:00 P.M., with						
	the Administrate	or indicated the CNA had					
		on a psychiatric unit					
	1 ^	and cared for Resident #K					
		ted "it's a mindset from					
	_	I." He indicated CNA #5					
	and resident righ	ced on the abuse policy					
	and resident righ	its previously.					
	An attempt was	made to interview					
	-	9/30/11 at 10:30 A.M.					
	The resident did	not respond to questions					
	when asked.	•					
		clinical record was					
		9/11 at 9:30 A.M. The					
		the resident was admitted					
	1	which included, but were					
		oronary artery disease,					
		accident (stroke), renal					
	msummerciency, an	d gastrointestinal bleed.					
	A Minimum Dat	ta Set (MDS) significant					
		ent, dated 8/9/11,					
	1	ident was cognitively					
	intact.						
	1	lent Reporting Form,"					
		ndicated "The resident					
		ted today 9/23/11, that					
	the QMA 'slamn	ned her dinner tray down					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER.		LIA (X	2) MULTIPLE CO	NSTRUCTION	ļ	X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ	BUILDING	00		COMPLI	ETED
		155787		WING	-		09/30/20	011
					DDRESS, CITY, STA	ATE. ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEI	R			RIVER RD	,		
INDIANA	VETERANS HOM	E			_AFAYETTE, IN	47906		
(X4) ID	CHMMADVC	STATEMENT OF DEFICIENCIES	2	ID	•		1	(V5)
PREFIX		ICY MUST BE PERCEDED BY 1	1	PREFIX		PLAN OF CORRECTION /E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMA		TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT TICIENCY)	E	DATE
1110		walked away and didn		1710				DATE
		•						
	-	sident reported that she						
		e employee" The QM						
	was suspended pending completion of an							
	investigation.							
	An e-mail from	RN #3 to ADON #1,	1					
	dated 9/23/11, ir	ndicated "Resident						
	· ·	oyee does not like her a	and					
	•	he resident is afraid of						
		Resident denies that this						
		armed the resident. The						
			,					
		fied by the resident is	,					
		dent also stated she thin	ıks					
		oyee is waiting for the						
	opportunity to ir	ritate her"						
	_	on" form, dated 9/23/11	-					
	indicated "Res	ident stated that emplo	yee					
	slammed a tray	down on the over bed						
	table & res is afi	raid of employeeDid	the					
	incident/allegati	on meet the definition	of					
	_	eled)Resident felt it w	I .					
	`	its were interviewed. N						
		ntResident states she						
	•	med but continues to b						
			1					
		bee using a pocket talke	I .					
		(abdomen) which coul						
		noiseUnsubstantiated	1					
		(CNA #9) returned to	0					
	work & has been	n re-educated on the	1					
	policyContinu	es to be afraid of						
	employee but ca	n't state why"						
		-						
FORM CMS-2	567(02-99) Previous Versi	ons Obsolete Eve	ent ID: 92XN	//11 Facility I	D: 001134	If continuation sh	eet Pac	ge 31 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155787	B. WINC			09/30/20	J11
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			RIVER RD .AFAYETTE, IN47906		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	BROWNER WANTER CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	Documentation was lacking related to any						
	other staff being interviewed related to the						
	above incident of	f alleged abuse.					
	An e-mail from t	he Psychiatric Services					
		ON #1, dated 9/26/11,					
	-	ou talk to the alert and					
	oriented resident	s on (unit name) on					
	Friday? If so can	you tell me who they					
		ey said. I need to get the					
	employee back to	o work."					
	Interview on 9/29	9/11 at 1:00 P.M., with					
		ted no other staff					
		en interviewed. She					
	indicated the resi	dent continues to state					
	she's afraid of the	e employee. ADON #1					
	indicated "she pr	obably passes meds to					
	her."						
	Interview on 0/2	9/11 at 1:00 P.M., with					
		r indicated "I am not					
		v staff every time					
	~ ~	ey're afraid of staff. We					
	-	nds to do that. I won't					
		und. That's not going to					
	happen."						
	On 9/29/11 at 9:20 A.M., an attempt was						
		w Resident #F. The					
		entrance to her room and					
	would not speak with surveyor.						
	4. Resident #J's	clinical record was					

		AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		ULTIPLE CO LDING G	NSTRUCTION 00	(X3) DATE (COMPL 09/30/2	ETED
	PROVIDER OR SUPPLIER			3851 N	DDRESS, CITY, STATE, ZIP CODE RIVER RD .AFAYETTE, IN47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	reviewed on 9/30 record indicated with diagnoses who the limited to, in anxiety, demention of the limited to, in anxiety of the limited to, in anxiety, demention of the limited	o/11 at 10:40 A.M. The the resident was admitted which included, but were somnia, depression, a, and psychosis. a Set (MDS) quarterly d 8/29/11, indicated the erely impaired in on-making skills, was and required extensive ical assistance for bed		TAG			DATE
	dated 6/16/11, in alert and oriented	ent Reporting Form," dicated "Resident is I with some e reports that 2 aides that					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787				LDING	NSTRUCTION 00	(X3) DATE COMPI 09/30/2	ETED
NAME OF I	PROVIDER OR SUPPLIEI	}	p. ,, 11		ADDRESS, CITY, STATE, ZIP CODE		
					RIVER RD		
	VETERANS HOM	<u> </u>		WEST	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
TAG		at him to bed was 'rough'		IAG			DATE
	with him, that th						
	is a hoyer liftP						
		resident did not get out					
		dayCNA's will be					
	inserviced on the	-					
		was lacking related to					
		the staff was who had					
	, ,	of the alleged incident.					
		C					
	An "Investigation" form, dated 6/17/11,						
	_	the incident/allegation					
	meet the definiti	on of abuseYes					
	(circled)After	investigation - it was					
	noted that reside	ent did not get OOB (out					
	of bed) that day!	(per Unit					
	Manager)Unsu	ubstantiated (indicated by					
	checkmark)"	Documentation was					
	lacking related to	o identification of staff					
	involved in incid	dent or documentation of					
	any other staff in	nterviews related to the					
	incident of alleg	ed abuse.					
		clinical record was					
		9/11 at 11:00 A.M. The					
		the resident was admitted					
	_	which included, but were					
	not limited to, po						
		seizures, difficulty					
		and severe chronic					
	obstructive pulm	ionary disease.					
	A Minimum D	to Cat (MDC) as a set of					
		ta Set (MDS) quarterly					
	assessment, date	ed 6/16/11, indicated the					

		X1) PROVIDER/SUPPL	IER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	Δ RIII	LDING	00		COMPL	ETED
		155787		B. WIN				09/30/2	011
				J. WIIV		ADDRESS, CITY, STA	ATE. ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R				RIVER RD	_, 0051		
INDIANA	VETERANS HOM	E				_AFAYETTE, IN	47906		
			N. GIEG	1					(7/5)
(X4) ID		STATEMENT OF DEFICIE			ID		PLAN OF CORRECTION /E ACTION SHOULD BE		(X5)
PREFIX TAG	•	NCY MUST BE PERCEDE			PREFIX TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT	E	COMPLETION DATE
TAG		R LSC IDENTIFYING INF			TAG		Telester,		DATE
	resident was cognitively intact and was								
	independent in transfers, ambulation, and								
	toilet use.								
	Nurses' notes, da	ated 9/10/11 at 10:	:30						
	A.M., indicated	"Resident reported	d to						
	-	ave her a shower							
	_	a male aide showe	• .						
	_	with her cross nec							
		ther nurse aide sta							
		told her the same t							
	_		ining but						
	•	ior to that - states							
		ing - was possible							
		shirt off, necklace	-						
	caught and came	e offwhile securi	ty was						
	doing search, res	sident changed her	r story						
	to male aide can	ne up behind her v	vhile						
	she was naked a	nd choked her wit	h the						
	necklace and the	en took it. Supervi	sor						
	notified."		~ ~ ~						
	notified.								
	Dogumentation	waa laakina ralata	d to on						
		was lacking relate							
		ing conducted the							
	•	when the resident							
	reported it to a C	CNA.							
	A social service	note, dated 9/12/1	1,						
	indicated "Me	t with resident to f	follow						
	up regarding alle	egation against sta	iff -						
		at can not identify							
	_	out. Resident main							
	-	ough there does no							
	_	dence to support							
	allegations"	defice to support							
	anegations								
FORM CMS-2	567(02-99) Previous Versi	ons Obsolete	Event ID:	92XM11	Facility 1	^{ID:} 001134	If continuation sh	eet Pa	ge 35 of 47

				X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787			4	A. BUILD	ING	00			
		155767	E	B. WING				09/30/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	ATE, ZIP CODE		
						RIVER RD			
INDIANA	VETERANS HOME	E			WEST L	AFAYETTE, IN	47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			ID	PROVIDER'S P	LAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FU			REFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	ON)		TAG	DEF	TCIENCY)		DATE
	A "Facility Incident Reporting Form,"								
	dated 9/10/11, indicated "Resident is alert,								
	but has periods of confusion. She reported								
	to a staff member	er, that approx							
	(approximately)	2 weeks ago, while she							
	was in the showe	er room a male who was							
	giving her a show	wer came up behind her,							
		s necklace and tried to							
	~	aid it was choking her							
	*	•							
	until it broke. She does not remember who it was poss (possibly) a male CNA								
		She later reports it was							
	` ′	•	.)						
	` ′	male CNA named (name	e)						
	on schedule to w	ork"							
	A handrinittan na	ata datad 0/10/11 and							
		ote, dated 9/10/11 and							
		#11) indicated "She							
		e that she reported him.							
	`	w his name, just that he							
	had a smirk on h	is face)"							
	A 1 1 10	1 1 1 1 1 1 1 1							
		ote, dated 9/10/11 and							
	signed by (CNA	* ·							
		eks ago a male aid (sic)							
	• • • •	gave (Resident #G) a	_						
		ternoon. At that time had	d l						
	not heard any iss	sues or problems or							
	_	ut a week ago, (Resident	t						
	#G) mentioned tl	hat someone came up							
	behind her & sto	ole her cross when she go	ot						
	a shower from a	male aid (sic). Mentione	ed						
		gency nurse - said she ha							
heard something about it already. It									
FORM CMS-2	2567(02-99) Previous Version		ID: 92X		Facility II	D: 001134	If continuation sh	eet Pa	ge 36 of 47

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/30/2	ETED	
		155767	B. WIN		DDDEGG CITY OTATE ZID CODE	09/30/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ner sweater pulled off her		1710			DATE
	necklace."	ioi sweater panea on her					
	A handwritten no	ote, dated 9/12/11, and					
		W #2 indicated "Spoke c					
	1 -	per phone about incident					
		nt #G). She states she					
	does not recall be	eing informed of any					
	incidents. Inform	ed her to review P&P					
	(policy and procedure) on abuse before						
	returning to IVH. She states she is aware						
		e importance of notifying					
		nny c/o (complaints of)					
	abuse to be inves	stigated!"					
	An "Investigation	n" form, dated 9/10/11,					
	indicated "Did	the incident/allegation					
	meet the definition	on of abuseYes					
		#13) reviewed abuse					
	policy(LPN #2)	,					
		a history of making false					
	`	A #13) states he does not					
		g any jewelry & she did					
	most of her bathi	•					
	checkmark)"	antiated (indicated by					
	checkinark)						
	Interview on 9/29	9/11 at 1:00 P.M., with					
		ed the incident had not					
	been reported or	investigated prior to					
	9/10/11.						
	An e-mail of 4/2	7/11 at 3:28 P.M., from					
		#4, RN #5, RN #6, RN					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUIL	DING	nstruction 00	(X3) DATE S COMPL 09/30/20	ETED	
		100707	B. WINC		DDDEGG GITY GTATE ZID GODE	00/00/20	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE RIVER RD		
	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)] 1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		,		TAG			DATE
		road Band Executive, the					
	DON, and ADON #1 indicated "Past couple of months we have noticed an						
	•	and 'abuse' on (unit					
		re had to be reportables.					
	The issue is that	•					
		ne unit so we need to					
	•	aware and that we have					
		placeI will just need to					
		have some kind of proof if state would come in to show them"					
	come in to snow	come in to snow them					
	Interview on 9/29	9/11 at 1:15 P.M., with					
		r indicated "If somebody					
		vant staff in the room, I					
		onal staff. I won't replace					
		going to happen. You					
		e not to come in the					
	1	e what CMS says. You do					
	what you (ISDH)						
		dicated staff were not to					
		th ISDH unless he was					
		ted staff to leave the					
	room.	ted starr to reave the					
	100111.						
	Review on 9/28/	11 at 11:30 A.M., of a					
		d procedure, dated					
		ed by the Assistant					
	· •	lentified as current, and					
		entification, Prevention					
	and Reporting" in						
		stances of abuse of all					
	•	hose in a coma, cause					
	physical harm, or	· ·					
	/	-	-				

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
	155787	A. BUILDING B. WING		09/30/2011	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE	l	
			RIVER RD		
INDIANA	VETERANS HOME		AFAYETTE, IN47906		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	anguishThe facility staff monitors the				
	facility environment including, but not				
	limited tostaff deploymentEmployees				
	are asked to report suspected or actual				
	abuse immediately to the nurse in charge,				
	or in the event the incident occurs in an				
	area off the nursing unit, to the supervisor				
	in that area, who will report to the nursing				
	supervisor immediatelyIt is the intent of				
	the Indiana Veterans Home to investigate				
	all allegations (witnessed/confirmed or				
	NOT) of abuse, neglect, involuntary				
	seclusion or misappropriation of Resident				
	propertyWritten statement will be obtained from involved parties, including				
	the suspected employee, the Resident (if				
	possible, as above), and potential				
	witnesses"				
	Williesses				
	This federal tag relates to Complaint				
	Number IN00097132.				
	3.1-28(a)				
F9999					
1'7777					
	3.1-28 STAFF TREATMENT OF	F9999	1. What action was taken to	10/31/2011	
	RESIDENTS		correct the deficient practice affected residents? Families		
			doctors were notified immed		
	(c) The facility must ensure that all		for residents involved in repo	orted	
	alleged violations involving mistreatment,		incidences 2. How are other	rs	
		•		-	

	/IDER/SUPPLIER/CLIA CATION NUMBER: 7	(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPLI 09/30/20	ETED
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME		D. WINC	STREET AI	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN47906		
	ing injuries of isappropriation of ported instrator of the ls in accordance stablished the state survey in every event further expected investigation is the investigation is the last evidenced and interview, the hly investigate in a thallegations of C, and D).		3851 N F	RIVER RD	e and control of the	(XS) COMPLETION DATE
Resident C's clinical rec on 9/28/2011 at 11:42 A	M.	2XM11	Facility II	D: 001134 If continuation sl	neet Doo	ge 40 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155787		A. BUIL	DING	NSTRUCTION 00	(X3) DATE (COMPL 09/30/2	ETED	
		155767	B. WING		DDDDGG GETY GTATE TIP CODE	09/30/20	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME				AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Resident C's diag	gnoses included, but were					
	not limited to, de	mentia with behaviors,					
	anxiety, Alzheimer's Disease, depression,						
	and a history of a	a CVA (stroke).					
	Review of the Nu	urses' notes, dated					
	9/24/2011 at 1330 (1:30 P.M.), LPN #1						
	wrote " Also a	* '					
	` ′	hushed tone 'I'm scared.'					
	(W) (writer) reassured her that is a safe						
	place and we would all care for her"						
	Resident C's quarterly MDS (Minimum						
	Data Set) assessr	ment, dated 8/12/2011,					
		s assessed as being					
		d for decision making					
		and long term memory					
	1 ^	vas assessed as needing					
	eating.	nce of one person with					
	eating.						
	The facility prov	ided a file with the					
		nn incident with the					
	following inform	ation:					
	There was a hand	dwritten note, dated					
		gned by CNAs #3 and					
	· ·	PN #1) told to put					
		ed when that would					
	mean she would	miss her meal. If					
	` '	oisy I am told to put her					
		gets close to time to get					
	_	red to again to leave her					
	in bed. So she m	nisses her meal. When					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155787	B. WIN	G		09/30/2	011
NAME OF I	PROVIDER OR SUPPLIEI	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
IN ID IAN IA	\((= \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	_			RIVER RD		
INDIANA	VETERANS HOM	E		WESTL	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		kes noise it unnerves		TAG			DATE
	` ′						
	(LPN #1) - she has said this many times & that she can't stand (Resident C) around						
	her when she's like that'"						
	ner when she's fixe that						
	The investigation	n conclusion was this was					
	_	The nurse was to be					
	re-educated about meal intakes and the						
	CNA's about abuse and the charge nurse						
	responsibilities.						
	1						
	Documentation was lacking related to any						
	other staff memb	pers being interviewed					
	related to the abo	ove incident of alleged					
	abuse.						
		nail, dated 9/20/2011 at					
	4:34 P.M., from	ADON #1 to the					
		dicating, " this is the					
		e CNA turned in last					
	· ·	we need to look at moving					
	some the CNA's	off that unit"					
		0/11 / 1.00 P.3.5					
		9/11 at 1:00 P.M., with					
		ted "the CNAs don't like					
	,	†1) is doing. All the					
		because she is making					
		e. (LPN #1) put her					
	` ′	wn because she needed					
	_	re her a snack. If she's					
	know if she got	n't wake her up. I don't					
	Know it she got	iunen.					
	2. During the fac	cility tour on 9/28/2011 at					
	2. During the lat	71111 tour on 7/20/2011 at					

001134

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155787		A. BUILE	DING	00		COMPL 09/30/2	
		100767		B. WING				09/30/2	011
NAME OF P	PROVIDER OR SUPPLIER	8				ADDRESS, CITY, ST	TATE, ZIP CODE		
INIDIANIA	VETEDANIO LIONI	_				RIVER RD	147000		
INDIANA	VETERANS HOME	=			WESIL	_afayette, In	N47906		
(X4) ID		TATEMENT OF DEFICIENCIES			ID		PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		P	REFIX	CROSS-REFEREN	IVE ACTION SHOULD BE CED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	١)		TAG	DE	EFICIENCY)		DATE
		Unit Manager #1, she							
	identified Resident A as being								
	interviewable.								
	Resident A was interviewed on 9/29/2011								
	at 9:30 A.M. He	e indicated that LPN#1							
	had come into hi	s room one day and told							
	him he needed to	take a bed bath. He							
	indicated he told	her he didn't need one.							
		n his hair smelled and							
		lay there and stink. He							
	indicated he told her to get out of his								
		indicated she was a very							
		was constantly giving							
	•	ne didn't like it. He said							
		would not be coming back							
		im, but that she had been							
	back to take care	e of him.							
	Tille Contille to the	1							
	_	dent reporting form, dated							
	6/19/2011, indica	ated the following:							
	•	n of incident: Resident is							
		d. He had been deemed							
		e psychologist. Resident							
	explained consec	quences of refusing meds							
	by nurse and felt	she was disrespectful to							
	him."								
	The facility unsu	ibstantiated this							
	complaint.								
	Documentation v	was lacking related to any							
		pers being interviewed							
FORM STATE					D		TO		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID	: 92×	(M11	Facility 1	D: 001134	If continuation sh	leet Pa	ge 43 of 47

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	155787		LDING	00	09/30/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		ove incident of alleged	+	TAG			DATE
	abuse.	ove including of aneged					
	douse.						
	This state tag relates to Complaint #IN00097132.						
	3.1-28(c)						
	3.1-28(d)						
	3.1-27 ABUSE AND NEGLECT						
		has the right to be free					
	from verbal abus	e.					
	This state rule w	as not met as evidenced					
	by:	as not met as evidenced					
	<i>y</i> .						
	Based on record	review and interview, the					
		ensure an allegation of					
	1	thoroughly investigated					
	for 1 allegation of	of verbal abuse made by 1					
	of 1 resident in a	sample of 4 residents					
	with allegations	of abuse (Resident A).					
	Findings include	:					
		212					
	_	ility tour on 9/28/2011 at					
		Unit Manager #1, she					
	identified Reside	ent A as being					
	interviewable.						
	Resident A was i	interviewed on 9/29/2011					
		indicated that LPN#1					
	1 22 7.50 71.101. 110	marada mar Di i mi i					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155787	B. WIN			09/30/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOMI	E			RIVER RD _AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		is room one day and told					
		take a bed bath. He					
	indicated he told her he didn't need one.						
	She then told him his hair smelled and						
	that he could not lay there and stink. He						
		indicated he told her to get out of his					
		oom. He further indicated she was a very					
	_	was constantly giving					
		ne didn't like it. He said					
	he was told she						
	to take care of him, but that she had been						
	back to take care of him.						
	staff member on the staff member LPN #1 tell Resi he needed a bath she had not been facility about thi Resident A's clir on 9/29/2011 at Resident A's dia not limited to, C failure), PVD (p	nical record was reviewed					
	retinopathy, and	• •					
		as 15 of 15. His 8/1/2011					
	·	as 13 of 13. His 8/1/2011 Data Set) assessment					
	`	,					
	maicatea ne nad	modified independence					

001134

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155787	B. WIN			09/30/2	U11
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
INIDIANIA	VETERANG HOM	_			RIVER RD		
	VETERANS HOMI			<u> </u>	_AFAYETTE, IN47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG	for decision mak	·	+	IAG			DATE
	101 decision mak	ding skins.					
	The facility incid	dent reporting form, dated					
	6/19/2011, indicated the following:						
	0/19/2011, maic	ated the following.					
	"Brief description	Brief description of incident: Resident is					
	alert and oriented. He had been deemed						
		e psychologist. Resident					
		quences of refusing meds					
	by nurse and felt she was disrespectful to him."						
	111111.						
	I PN #1 was plac	ced on suspension.					
	Li iv #i was piac	ced on suspension.					
	The description	of the incident was					
		rse (LPN #1) was					
	disrespectful to l						
	_	ester him after he told her					
	to get out of res.						
	to get out of ies.	TOOIII.					
	An email from N	MSW #2 to ADON #2,					
		ndicated "nurse over the					
		estering me about not					
	_	estering me about not taking meds, blood test.					
		- which I did not sign."					
	anu iciusai ioiiii	- which I did not sign.					
	The facility unsu	shetantiated this					
	_	iosiaillateu tiiis					
	complaint.						
	Documentation	was lacking related to any					
		_					
		pers being interviewed					
		ove incident of alleged					
	abuse.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIE IDENTIFICATION NUME		(X2) MU	JLTIPLE CO	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155787	DEK:	A. BUIL		00		09/30/2	
		133707		B. WIN				09/30/2	011
NAME OF F	PROVIDER OR SUPPLIER	_				DDRESS, CITY, STA	TE, ZIP CODE		
INIDIANA	VETEDANO LIONA	=				RIVER RD .AFAYETTE, IN4	17006		
	VETERANS HOME					ACATELLE, IN4	+1 900		
(X4) ID		TATEMENT OF DEFICIEN			ID	PROVIDER'S PL	AN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED LSC IDENTIFYING INFO			PREFIX TAG	CROSS-REFERENCEI	D TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
IAG		9/11 at 1:15 P.M.,			IAG				DATE
		or indicated "If som							
	says they don't want staff in the room, I won't hire additional staff. I won't replace								
		-							
	staff. That's not going to happen. You can't tell everyone not to come in the								
	•								
	room. I don't car	I don't care what CMS says."							
	_	ates to Complaint							
	#IN00097132.								
	2.4.274								
	3.1-27(b)								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID:	92XM11	Facility I	D: 001134	If continuation sh	eet Pac	ge 47 of 47